CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: WWW.DPR.DELAWARE.GOV

BIENNIAL REGISTRATION/RENEWAL APPLICATION FOR PHYSICIAN ASSISTANTS

(For Office of Controlled Substances Drugs Use Only):				
License No.	**Renewal Date**	**Amt. Rec'd.**	**Check No.**	**Date Rec'd.**

PLEASE PRINT OR TYPE

SECTION A - **PERSONAL DATA** (*Do not use a post office box address*)

NAME AND HOME ADDRESS (LAST, FIRST, MIDDLE INITIAL)		
DATE OF BIRTH	**HOME PHONE**	**WORK PHONE**
DRIVER LICENSE NUMBER	**STATE**	**SOCIAL SECURITY NUMBER**
DELAWARE PHYSICIAN ASSISTANT LICENSE NO.	**EXPIRATION DATE**	
PRESCRIBER I.D. NO. RXAPN:		

SECTION B - **DISCLOSURES**

1. □ **Yes** □ **No** — Has the applicant ever been convicted of a crime in connection with controlled substances under State or Federal law?

2. □ **Yes** □ **No** — Has the applicant ever surrendered or had a Federal controlled substances registration revoked, suspended, restricted, or denied?

3. □ **Yes** □ **No** — Has the applicant ever had a State professional license or controlled substances registration revoked, suspended, denied, restricted, or placed on probation?

4. □ **Yes** □ **No** — If the applicant is a corporation (other than a corporation whose stock is owned and traded by the public), association, partnership, or pharmacy, has any officer, partner, stockholder or proprietor been convicted of a crime in connection with controlled substances under State or Federal law, or ever been suspended, restricted or denied, or ever had a State professional license or controlled substances registration revoked, suspended, denied, restricted, or placed on probation?

*** If the answer to any of the above questions is yes, please attach a letter setting forth the circumstances of such action.**

SECTION C - **PRACTICE DATA** (*List name, practice location and practice specialty of Supervising Physician(s) - attach additional sheets as necessary. Do not use a post office box address.*)

1. PRIMARY PRATICE LOCATION_____

   CITY_____ STATE_____ ZIP_____ PHONE_____

2. SUPERVISING PHYSICIAN_____ SPECIALTY_____

3. ALTERNATE SUPERVISING PHYSICIANS (*Address, if different than above*)

   A. NAME_____ SPECIALTY_____DEA#_____

   ADDRESS_____ CITY_____ STATE_____ ZIP_____

   B. NAME_____ SPECIALTY_____DEA#_____

   ADDRESS_____ CITY_____ STATE_____ ZIP_____

   C. NAME_____ SPECIALTY_____DEA#_____

   ADDRESS_____ CITY_____ STATE_____ ZIP_____

SECTION D - **PRESCRIPTIVE DATA**

The Physician Assistant identified on this form is authorized to prescribe under my supervision the following controlled substances:

1. SUPERVISING PHYSICIANS

   A. NAME_____ SCHEDULES

   SIGNATURE_____DATE_____ ☐ **II** ☐ **III** ☐ **IV** ☐ **V**

   Physician Assistants may request and issue professional samples of controlled legend medications. Are you delegating this authority? ☐ Yes ☐ No

   STATE CONTROLLED SUBSTANCES NO. _____ FEDERAL DEA NO._____

   B. NAME_____ SCHEDULES

   SIGNATURE_____DATE_____ ☐ **II** ☐ **III** ☐ **IV** ☐ **V**

   Physician Assistants may request and issue professional samples of controlled legend medications. Are you delegating this authority? ☐ Yes ☐ No

   STATE CONTROLLED SUBSTANCES NO. _____ FEDERAL DEA NO._____

   C. NAME_____ SCHEDULES

   SIGNATURE_____DATE_____ ☐ **II** ☐ **III** ☐ **IV** ☐ **V**

   Physician Assistants may request and issue professional samples of controlled legend medications. Are you delegating this authority? ☐ Yes ☐ No

   STATE CONTROLLED SUBSTANCES NO. _____ FEDERAL DEA NO._____

   D. NAME_____ SCHEDULES

   SIGNATURE_____DATE_____ ☐ **II** ☐ **III** ☐ **IV** ☐ **V**

   Physician Assistants may request and issue professional samples of controlled legend medications. Are you delegating this authority? ☐ Yes ☐ No

   STATE CONTROLLED SUBSTANCES NO. _____ FEDERAL DEA NO._____

SECTION E - **CERTIFICATION**

By signing this form, the applicant and each Supervising Physician agrees to promptly notify in writing the Board of Medical Practice of all changes (additions or deletions) of Supervising Physicians and of the schedules authorized.

I certify that the facts stated in this application are true, complete and correct and that this application is made to obtain biennial registration, pursuant to the Uniform Controlled Substances Act.

MAIL APPLICATION TO: **FEE: $40.00** **(MAKE CHECK PAYABLE TO "STATE OF DELAWARE")**

OFFICE OF CONTROLLED SUBSTANCES
CANNON BUILDING
861 SILVER LAKE BLVD. SUITE 203
DOVER, DELAWARE 19904

_____ _____
(Signature) *(Date)*

_____
NAME (*typed or printed*)

FOR STATE USE ONLY:

APPROVED_____DATE_____

P.A. REGULATORY COUNCIL BY_____

APPROVED_____DATE_____

BOARD OF MEDICAL PRACTICE BY_____